U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 13 August 2007

In the Matter of
Mr. K.P.R.[1]
Claimant

v.

EASTERN COAL CO.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Case No.: 2005 BLA 5263

Appearances: Ms. Brenda Yates, Personal Representative
For the Claimant

Mr. Joseph W. Bowman, Attorney
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER –
AWARD OF BENEFITS

This matter involves a claim filed by Mr. K.P.R. for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

[1]Chief Administrative Law Judge John Vittone has directed that I substitute initials for the names of the Claimant and all family members. Any comments or concerns regarding this mandated practice should be directed to Chief Administrative Law Judge John Vittone, 800 K Street, Suite 400N, Washington, D.C. 20001.

Procedural Background

Mr. R. filed his claim for federal black lung disability benefits on May 27, 2003 (DX 2).[2] On July 28, 2004, the U.S. Department of Labor ("DOL") awarded benefits starting May 1, 2003 (DX 54). On August 25, 2004, the Employer requested a formal hearing before the Office of Administrative Law Judges ("OALJ") (DX 56). On September 1, 2004, the DOL notified Mr. R. that the black lung disability trust fund would begin making payments (DX 58). The OALJ received the claim on November 23, 2004 (DX 60-62). At a hearing before Administrative Law Judge William S. Colwell on April 6, 2003, the Claimant requested a delay to obtain an attorney, and Judge Colwell granted a continuance. Mr. R.'s second hearing before Judge Colwell was held on October 13, 2005, and the claim was continued following the Employer's request for time to develop evidence responsive to late-submitted evidence by the Claimant. Pursuant to a Notice of Hearing dated May 18, 2006, I conducted a hearing in Abingdon, Virginia on September 13, 2006 with Mr. R., Ms. Yates, and Mr. Bowman.

Evidentiary Discussion

During my adjudication of the claim, I discovered that Dr. Hippensteel referenced his interpretations of chest x-rays from June 7, 2004 and December 1, 2005.

The June 7, 2004 chest x-ray was a treatment record. In *Henley v. Cowin & Co.*, BRB No. 05-0788 BLA (May 30, 2006), the Benefits Review Board ("BRB" or "Board") held that 20 C.F.R. § 725.414 does not allow for the rebuttal of treatment records. Therefore, Dr. Hippensteel's interpretation is inadmissible. Dr. Hippensteel's interpretation of the December 1, 2005 x-ray is the second interpretation of that x-ray offered by the Employer. This second interpretation is not admissible because it exceeds the regulatory limits for case-in-chief evidence contained in 20 C.F.R. § 725.414, and is not rebuttal evidence. Therefore, Dr. Hippensteel's interpretations of these two x-rays are inadmissible.

Although his comprehensive review makes sound medical sense, the evidentiary restrictions imposed by DOL, as interpreted by the BRB in *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98 (2006) (en banc), renders such thoroughness a legal mistake.

The consideration of the inadmissible evidence is problematic because under 20 C.F.R. §§ 725.414(a)(2)(i) and 3(i) "any chest X-ray interpretation, pulmonary function test results, blood gas studies . . . and physician opinions that appear in a medical report must each be admissible" under the regulations. Under *Harris*, when confronted with a medical opinion that contained evidence not admitted into the formal record, the BRB indicated that an ALJ may: a) exclude the report, b) redact the objectionable content, c) require a revised report, or d) consider the physician's reliance on the inadmissible evidence in deciding the probative value of the report.

[2]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

For Dr. Hippensteel's report, I will apply a combination of the second and fourth options. I will not use the objectionable content referenced by Dr. Hippensteel in the adjudication of Mr. R.'s claim. In regards to probative value, no adverse effect occurred because Dr. Hippensteel also reviewed interpretations of those chest x-rays that were admissible and consistent with his own interpretations that neither x-ray contained a large opacity.

Additionally, Dr. Fino reviewed the August 19, 1995 chest x-ray, which showed scarring or fibrosis in Mr. R.'s lower lungs. This x-ray is not in the record in this claim, and because it is a treatment record, Dr. Fino's interpretation of it is not admissible under *Henley*. Therefore, applying the second and fourth *Harris* options again, I will remove Dr. Fino's discussion of the x-ray from my summary, and I find that the probative weight of Dr. Fino's opinion is not reduced because of the other admitted chest x-rays that Dr. Fino reviewed which support his findings on the location of abnormalities in Mr. R.'s lungs.

My decision in this case is based on the hearing testimony and the following documents admitted into evidence: DX 1 to DX 62, CX 1 to CX 7, EX 1 to EX 9.

ISSUES

1. Length of coal mine employment and responsible operator.

2. Whether Mr. K.P.R. has pneumoconiosis.

3. If Mr. K.P.R. has pneumoconiosis, whether his disease arose out of coal mine employment.

4. Whether Mr. K.P.R. is totally disabled.

5. If Mr. K.P.R. is totally disabled, whether his disability is due to coal workers' pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the hearing, the parties stipulated to the following facts: a) Mr. R. was a coal miner with post-1969 coal mine employment, and b) Mrs. T.R. is a dependent spouse for the purposes of augmenting any benefits that may be payable under the Act. (TR, p. 8-9)

Preliminary Findings

Born on September 15, 1927, Mr. R. married Mrs. T.R. on May 10, 1951. Mr. R. finished the 8th grade and spent 9 years in the U.S. Army. Mr. R. entered the mines in 1952 for 7 years. He returned to the mines in 1975, where he stayed until he retired in October 1996. Mr. R. worked as a shot fireman and foreman, and he also owned and operated some of the mining companies that contracted to mine coal for larger coal companies. For the last two to three years

of his employment, Mr. R. worked outside of the mine, occasionally escorting inspectors down into the mine. He pulled out his equipment and stopped mining coal when he stopped making money. Mr. R. smoked cigarettes from age 20 until 1995, at the rate of one pack or more each day. (DX 2, DX 6, and TR p.15-29)

Issue # 1 – Length of Coal Mine Employment and Responsible Operator

Eastern Coal Co. contests its designation as the responsible operator in this case because after working for Eastern, Mr. R. worked for Kenes Coal Co. for over a year. Neither the Director, nor the Claimant responded to this argument. As a first step in analyzing the responsible operator issue, I will set out Mr. R.'s employment history in detail.

Length of Coal Mine Employment

According to 20 C.F.R. § 718.301, the length of coal mine employment is calculated in accordance with 20 C.F.R. § 725.101(a)(32). Section 725.101(a)(32) defines a year of coal mine employment as a calendar year of 365 or 366 days, or partial periods equal to one year, during which a miner worked in or around coal mines for at least 125 working (i.e., paid) days.[3] If a miner worked at least 125 days in a calendar year or "partial periods totaling one year," then he is given credit for one year of coal mine employment.

The regulation sets out two ways to determine the length of coal mine employment. First, if the beginning and ending dates of coal mine employment can be ascertained and that time period spans a calendar year, then the miner receives credit for one year of coal mine employment. In that case, the regulation presumes the miner worked at least 125 days during that calendar year. 20 C.F.R. § 725.101(a)(32)(ii). Any credible evidence may be used to establish dates of employment, including, but not limited to, company records, co-worker affidavits, and sworn testimony. *Id*.

Second, if the evidence is insufficient to determine the beginning and ending dates of employment, or the employment covered less than a calendar year, 20 C.F.R. § 725.101(a)(32)(iii) sets out a somewhat complicated process to determine the length of coal mine employment using the miner's annual income and the coal mine industry's average daily earnings for that year, as reported by the Bureau of Labor Statistics.

According to Mr. R., he was employed as a coal miner and exposed to coal dust in 1945, from 1952 to 1959, and from 1975 to 1996.

Mr. R.'s testimony and documentary evidence were not sufficiently reliable to determine the actual start or end dates of employment for 1945 and the period of 1975 to 1979.

[3]The term "working day" is defined as "any day . . . for which a miner received pay for work as a miner, but shall not include any day for which the miner received pay while on approved absence, such as vacation or sick leave." Thus, while sick and vacation leave days may be counted as part of the calendar year for the purposes of showing the duration of an employment relationship, they do not qualify as part of the requisite 125 "working" days.

Consequently, the second, more elaborate method of calculating coal mine employment must be used.

Based on a combination of Mr. R.'s testimony and his other submissions, including Social Security Administration ("SSA") earnings records, I am able to determine Mr. R.'s coal mine employment as follows:

Year	Avg. Daily Wage ($)[4]	Coal Company	Annual Earnings ($)	Work Days[5]	Fractional Year[6]	Employ-ment Days	Cumulative Coal Mine Employment
1945	10.52	Carter Coal Co.	575.54	54.71	0.44	160	160 days
1945	10.52	Evans Pocahontas Coal Co.	4.63	0.44	0.00	1	161 days
1975	59.24	H&D Coal Co.	1,578.64	26.65	0.21	78	239 days
1976	64.07	H&D Coal Co.	3,729.69	58.21	0.47	170	1 year, 44 days
1977	71.90	H&D Coal Co.	9,021.87	125.48	1.00	366	2 years, 44 days
1978	80.31	H&D Coal Co.	15,420.90	192.02	1.54	561	3 years, 44 days
1979	87.03	H&D Coal Co.	9,592.50	110.22	0.88	322	5 years, 1 day

Mr. R. also reported work for Roberts Coal Co. from 1952 until 1959. This company was owned by Mr. R. and his brother, but Mr. R. did not provide any documentation of his earnings. Mr. R.'s Social Security statement only includes self-reported income for the years 1956 ($5,892.33) and 1957 ($6,460.35). Because Mr. R. appears to have been farming at the same time, I cannot be sure that the reported income is solely from his coal mining. Therefore, I do not include it in Mr. R.'s coal mine employment.

The record contains sufficient evidence of the beginning and end dates of Mr. R.'s work after November 1979, so I will use the first method to determine Mr. R.'s length of coal mine employment for that period. In his request for federal black lung disability benefits, Mr. R. wrote that he was employed from November 1979 until July 1993 by Eastern Coal Co., a partnership in which he was a partner. He confirmed this at his hearing and in deposition, and also provided his federal tax returns with detail on the annual earnings and losses for Eastern Coal Co. This establishes 13 years and 9 months of coal mine employment.

Additionally, Mr. R. wrote that from March 1994 until March 1995 he was employed by Kenes' Coal Co., a coal mining contractor owned by Mr. R. as the sole shareholder. Kenes' Coal Co. was an "S" corporation for which Mr. R. filed federal tax returns in 1996 and 1997. His testimony was that he operated Kenes' Coal Co. from March 1994 until October 1996, and that operations were halted for three months during Mr. R.'s hernia operation. This establishes 2 years and four months of coal mine employment.

[4]*See* Attachment 1.

[5]Work Days = Annual Earnings / Average Daily Wage

[6]Fractional Year = Work Days / 125 days. If the result is greater than 1, the miner receives no more than 1 year of credit for coal mine employment. 20 C.F.R. § 725.101(a)(32)(i).

Based on the employment data provided by Mr. R. on his application and his hearing testimony, and in the absence of any evidence to the contrary, I find that Mr. R. had 21 years, 1 month, and 1 day of coal mine employment.

Responsible Operator

Under 20 C.F.R § 725.495(a)(1), liability for benefits under the Act is assessed against the coal mine operator that meets the requirements set out in 20 C.F.R. § 725.494 that most recently employed the miner. While 20 C.F.R. § 725.494 establishes numerous criteria for the designation of a "potentially liable" operator, the relevant requirements for this claim are (1) length of employment, and (2) capability of assuming liability for payment of benefits. According to 20 C.F.R. § 725.494(c), the miner must have been employed by the operator for a cumulative period of not less than one year, as defined in 20 C.F.R. § 725.101(a)(32). Additionally, under 20 C.F.R. § 725.494(d), the operator must be capable of assuming its liability for the payment of benefits under the Act.

As a result, part of the process of identifying the responsible operator involves identifying the most recent operator and working backwards in time until an operator satisfies the regulatory requirements.[7]

After operating Eastern Coal Co. for 13 years and 9 months as a partnership, Mr. R. decided to use the equipment on his own under the name of Kenes' Coal Co. His testimony is that he relocated the mining equipment and tried to run a mine without the assistance of his son, who left coal mining to pursue farming (Tr. p.36-39, DX 45 Tr. p.34).

Eastern Coal Co. argues that Kenes' Coal Co. is the responsible operator in this claim because Mr. R. worked for that operator for not less than one year after he worked for Eastern Coal Co. I agree with Eastern Coal Co. that Mr. R. worked for Kenes' Coal Co. for over one year after his employment with Eastern Coal Co.

However, to be the responsible operator in this claim, Kenes' Coal Co. must meet the criteria under 20 C.F.R. § 725.494, including the ability of assuming liability for payments. This may be met in three ways under the regulations: (1) coverage under an insurance policy that covers the claim, (2) qualification as a self-insurer during the time the miner was employed by the operator, or (3) the operator's possession of sufficient assets to secure payment of benefits. 20 C.F.R. §§ 725.494(e)(1)-(3).

Before I evaluate Kenes' Coal Co.'s ability to pay benefits, I note that the regulatory amendments at 20 C.F.R. § 725.495(c)(2) shift the burden to require that the designated responsible operator establish "[t]hat it is not the potentially liable operator that most recently employed the miner." Therefore, it is Eastern Coal Co.'s burden to show that it is not the responsible operator in this claim. Because Eastern Coal Co. seeks to relieve its designation as

[7]*See Cole v. East Kentucky Colleries*, 20 B.L.R. 1-51 (1996); *Director, OWCP v. Trace Fork Coal Co. [Matney]*, 67 F.3d 503 (4th Cir. 1995), *rev'g in part sub nom., Matney v. Trace Fork Coal Co*., 17 B.L.R. 1-145 (1993).

responsible operator by shifting the designation to Kenes' Coal Co., the burden is on Eastern Coal Co. to show that Kenes' Coal Co. is capable of paying benefits.

Turning to Kenes' Coal Co.'s ability to pay benefits, first, when the company last operated, it was insured by Employer's Insurance of Wausau. DX 33, DX 45 Tr. p.14. The insurance coverage included workers' compensation, but not black lung claims. DX 45 Tr. p.13-14. Mr. R. testified that he did not have black lung insurance coverage because he did not know about it. *Id*. at p.14. Therefore, I find that Kenes' Coal Co. was not insured for federal black lung claims.

Second, the record does not contain any evidence that Mr. R. qualified as a self-insurer for black lung claims. In the absence of that evidence, I find that Kenes' Coal Co. was not self-insured against black lung claims.

Third, Kenes' Coal Co. does not appear to operate or exist any longer. Mr. R. denies working since October 1996 other than on his personal farm, and he also testified that he sold the remaining mining equipment for $25,000 in 2005. Tr. p.39. Therefore, Kenes' Coal Co. does not have sufficient assets with which to secure payment of benefits.

Therefore, since Kenes' Coal Co. cannot meet the requisite financial qualifications, it is not the responsible operator in this claim.[8]

Therefore, if Eastern Coal Co. meets the criteria under 20 C.F.R. § 725.494, then it is the responsible operator in this claim because, working back in time, it was the next employer to have employed Mr. R. for at least one year. At the hearing, counsel for Eastern Coal Co. noted that Eastern Coal Co. was insured against black lung claims through the Contractor's Self-Insurance Fund, which still exists but is now insured through Massey Energy. Tr. p.30-31. Therefore, Eastern Coal Co. meets the financial qualifications under 20 C.F.R. § 725.494(e)(1) because it is covered by an insurance policy.

Accordingly, the qualifications having been met, I specifically find that Eastern Coal Co., as insured by Massey Energy, is the responsible operator in this claim. Accordingly, the Eastern Coal Co.'s request to be dismissed as the responsible operator is denied.

Issue # 2 – Presence of Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[9] The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease . . . arising out of coal mine

[8]Even if Kenes' Coal Co. is a successor operator, that does not relieve Eastern Coal Co. of liability. Designation of a successor operator does not "relieve a prior operator of any liability if such prior operator meets the conditions set forth in § 725.494." 20 C.F.R. § 725.492(d). Therefore, even if Kenes' Coal Co. is a successor operator, because it is not capable of paying for black lung benefits, liability rests with Eastern Coal Co.

[9]20 C.F.R. § 718.201(a).

employment."[10] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[11] As several courts have noted, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202(a)(1)), autopsy or biopsy report (§ 718.202(a)(2)), regulatory presumption (§ 718.202(a)(3)),[12] and medical opinion (§ 718.202(a)(4)). Mr. R. has not submitted a biopsy report. As a result, Mr. R. will have to rely on a regulatory presumption based on the presence of complicated pneumoconiosis, chest x-rays, or medical opinion to establish the presence of pneumoconiosis. Additionally, under the guidance of *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), I must consider the chest x-ray evidence and medical opinion together to determine whether Mr. R. can establish the presence of pneumoconiosis in his lungs.

Complicated Pneumoconiosis

If a claimant establishes the presence of complicated pneumoconiosis, then an irrebuttable presumption of total disability due to pneumoconiosis is also established. 20 C.F.R. § 718.304.

In the Act, 30 U.S.C. 921(c)(3)(A) and (C), as implemented by 20 C.F.R. § 718.304(a), Congress determined that if a miner suffered from a chronic dust disease of the lung which "when diagnosed by chest x-ray, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C," there shall be an irrebuttable presumption that his death was due to pneumoconiosis.[13] This type of large opacity is called "complicated pneumoconiosis." The statute and regulation also permit complicated pneumoconiosis to be established by either the presence of massive fibrosis in biopsy and autopsy evidence or other means which would be expected to produce equivalent results in chest

[10]20 C.F.R. §§ 718.201(a)(1) and (2) (emphasis added).

[11]20 C.F.R. § 718.201(b).

[12]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a coal miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the coal miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the coal miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

[13]On the standard ILO chest x-ray classification worksheet, Form CM 933, large opacities are characterized by three sizes, identified by letters. Category A indicates the presence of a large opacity having a diameter greater than 10 mm (one centimeter) but not more than 50 mm; or several large opacities, each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B means an opacity, or opacities "larger or more numerous than Category A" whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

x-rays or biopsy/autopsy evidence. 30 U.S.C. 921(c)(3)(B) and (C) and 20 C.F.R. §§ 718.304(b) and (c). Additionally, a diagnosis of progressive massive fibrosis is consistent with a finding of complicated pneumoconiosis. The Supreme Court recognized complicated pneumoconiosis as "involv[ing] progressive massive fibrosis as a complex reaction to dust and other factors." *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7 (1976). Moreover, the U.S. Court of Appeals for the Fourth Circuit commented that complicated pneumoconiosis is also known "by its more dauntingly descriptive name, 'progressive massive fibrosis'." *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1359 (4th Cir. 1996).

According to the Fourth Circuit in *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), the existence of complicated pneumoconiosis is established by "congressionally defined criteria." As a result, the statute's definition of complicated pneumoconiosis as radiographic evidence of one or more large opacities categorized as size A, B, or C, 30 U.S.C. 921(c)(3)(A), represents the most objective measure of the condition. This sets the benchmark by which other methods for proving complicated pneumoconiosis are measured, as described in 30 U.S.C. 921(c)(3)(B) and (C). *Scarbro*, 220 F.3d at 256. In other words, whether a massive lesion or other diagnostic results represent complicated pneumoconiosis under 30 U.S.C. 921(c)(3)(B) and (C) requires an equivalency evaluation with the x-ray criteria set forth in 30 U.S.C. 921(c)(3)(A).[14] Additionally, the court emphasized that the legal definition of complicated pneumoconiosis as established by Congress controls over the medical community's definition of the disease. *Scarbro*, 220 F.3d at 257. Finally, the court indicated that although all relevant and conflicting medical evidence must be considered and evaluated,

> if the x-ray evidence vividly displays opacities exceeding one centimeter, its probative force is not reduced because the evidence under some other prong is inconclusive or less vivid. Instead, the x-ray evidence can lose force only if other evidence affirmatively shows that the opacities are not there or are not what they seem to be, perhaps because of an intervening pathology, some technical problem with equipment, or incompetence. *Id*.

Referencing a 1993 Fourth Circuit case, *Lester v. Director, OWCP*, 993 F.2d 1143, 1145-46 (4th Cir. 1993) the BRB in *Mullins v. Plowboy Coal Co.*, BRB No. 04-0716 BLA (July 8, 2005) (unpub.), emphasized that an ALJ "must weigh together all of the evidence relevant to the presence or absence of pneumoconiosis." That mandate is consistent with other case law indicating that all evidence relevant to whether the miner has pneumoconiosis must be weighed. *Gray v. SLC Coal Co.*, 176 F.3d 382 (6th Cir. 1999); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985).

In other words, even if the presence of large opacities is established through one of the three methods set out in § 718.304, all other medical evidence must be considered and evaluated to determine whether the large opacities actually exist and involve pneumoconiosis. For example, the BRB affirmed a finding of complicated pneumoconiosis under § 718.304 when the ALJ considered chest x-rays in conjunction with CT scan results to find complicated

[14] *See also* 20 C.F.R. §§ 718.304(b) and (c) (2001).

pneumoconiosis. *Keene v. G & A Coal Co.*, BRB No. 96-1689 BLA (Sept. 27, 1996). In another case, despite radiographic evidence of large opacities, the U.S. Court of Appeals for the Sixth Circuit upheld a determination that complicated pneumoconiosis did not exist based on probative autopsy evidence indicating the lesions were not complicated pneumoconiosis. *Gray*, 176 F.3d at 388.

In light of these statutory, regulatory, and judicial principles, the adjudication of whether a claimant is able to invoke the irrebuttable presumption under § 718.304 involves a three step process.

First, I must determine whether: a) the preponderance of the chest x-rays establishes the presence of large opacities characterized by size as Category A, B, or C under recognized standards; or b) biopsy evidence shows massive fibrosis; or c) other diagnostic results exist which are equivalent to the requisite chest x-ray or biopsy evidence of large opacities.

Second, if large opacities are established, I must also evaluate all the other relevant evidence in the record to determine whether it confirms or contradicts the presence of large opacities. In other words, I must assess whether the preponderance of the entire evidentiary record establishes the presence of large pulmonary opacities.

Third, if the preponderance of the evidence demonstrates the existence of large opacities, I must then consider all other relevant evidence to determine whether that evidence contradicts or supports a finding that the large opacities are indicative of complicated pneumoconiosis.

Existence of Large Opacities

In the absence of biopsy evidence, Mr. R. must rely on chest x-ray imaging, or other medical tests or means, to establish the presence of large opacities.

Chest X-Rays

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
June 26, 2003	DX 8, CX 6	Dr. Forehand, B	Positive for pneumoconiosis, profusion category 1/1,[15] type s/p opacities.[16] No large pulmonary opacity. Question of right hilar mass.

[15]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1. According to 20 C.F.R. § 718.102(b) (2001), a profusion of 0/1 does not constitute evidence of pneumoconiosis.

(same)	DX 9	Dr. Wheeler, B, BCR[17]	Negative for pneumoconiosis. (Negative for large pulmonary opacity.)[18] Ill defined lower lung markings compatible with pulmonary vascular prominence accentuated by underexposure or minimal interstitial infiltrates or interstitial fibrosis. Small linear scar in lateral periphery RUL, subtle thickening lateral portion minor fissure. Minimal arteriosclerosis aortic arch. No silicosis or CWP and asbestosis in lower lungs is very unlikely without obvious benign asbestosis-related pleural plaques.
Sept. 9, 2003	CX 6	Dr. Forehand, B	Positive for coal workers' pneumoconiosis. (Negative for large pulmonary opacity.) Continued clearing of basilar infiltrates.
March 17, 2004	DX 9A	Dr. Hippensteel, B	Positive for pneumoconiosis, profusion category 1/2, type s/t opacities. No large pulmonary opacities. Not suggestive of CWP. Arterioscleroses of aorta.
June 7, 2004	CX 5	Dr. Robinette, B[19]	Positive for pneumoconiosis, profusion category 1/0, type q/p opacities. Lungs expanded. No active infiltrate. Some mild degenerative changes to osseous structures. No large opacities. No definite pleural abnormalities.
May 19, 2005	CX 1	Dr. Alexander, B, BCR	Positive for pneumoconiosis, profusion category 2/2, type p/t opacities. Possible category A complicated coal workers' pneumoconiosis, 20mm x 10mm; could also be lung cancer.
(same)	CX 2	Dr. Pathak, B, British BCR	Positive for pneumoconiosis, profusion category 2/2, type q/t opacities. Category A opacity, 2 x 1.5cm. Emphysema. Mild cardiomegaly, bilateral COPD. Large opacity may represent progressive massive fibrosis or a neoplastic mass.
(same)	EX 8	Dr. Hippensteel	Positive for pneumoconiosis, profusion category 2/1, type t/t opacities. No large opacities. 2cm diameter opacity in left upper zone, new since 6/7/04, not consistent with complicated pneumoconiosis because of short time interval.

[16]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

[17]The following designations apply: B – B reader and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

[18]Since a physician evaluating a chest x-ray can be expected to accurately report the presence of any abnormalities, an administrative law judge may infer that the absence of a mention of pneumoconiosis indicates pneumoconiosis was not present. *See Marra v. Consolidation Coal Co.* 7 BLR 1-216, 1-219 (1985).

[19]I take judicial notice of Dr. Robinette's status as a NIOSH-approved B reader based on the list available at http://www.oalj.dol.gov.

(same)	EX 9	Dr. Fino, B	1x 2cm abnormality, middle portion of left lung; could be neoplasm, scar, or complicated pneumoconiosis.
December 1, 2005	EX 5	Dr. Fino, B	Negative for pneumoconiosis. (Negative for large pulmonary opacity.) Changes consistent with idiopathic interstitial pulmonary fibrosis.

Concerning the presence of a large pulmonary opacity, the four chest x-rays before May 19, 2005 are negative.

In the May 19, 2005 film, Dr. Pathak, Dr. Hippensteel,[20] and Dr. Fino identified a large pulmonary opacity. Dr. Alexander found a "possible" large pulmonary opacity that could represent lung cancer; an inconclusive interpretation. Setting aside Dr. Alexander's interpretation, the remaining interpretations demonstrate the presence of a large pulmonary opacity in the May 19, 2005 chest x-ray.

Based on Dr. Fino's uncontested opinion, the December 1, 2005 is negative for a large pulmonary opacity.

In summary, only one of the six films is positive for the presence of a large pulmonary opacity. Accordingly, the preponderance of the radiographic evidence fails to establish the presence of a large pulmonary opacity and Mr. R. is unable to establish the presence of complicated pneumoconiosis.[21]

Simple Pneumoconiosis

Before I consider the various interpretations of the chest x-rays for the presence of simple pneumoconiosis, I must address the manner in which I will treat at least one interpretation's comments. In *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1, 1-4 (1999) (en banc on recon.), the BRB discussed at least two types of comments that an interpreting physician might make along with a profusion finding of 1/0 or greater. First, the physician might comment that another disease cannot be ruled out, as in *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) (en banc). In this situation, the physician is making a comment that calls a diagnosis of pneumoconiosis into question. *Id*. at 1-37. Those comments should be evaluated within an administrative law judge's 20 C.F.R. § 718.202(a)(1) analysis about the presence of pneumoconiosis. If the comments suggest an alternative diagnosis, the "internal inconsistencies" may "detract from the credibility of the x-ray interpretation under 20 C.F.R. § 718.202(a)(1)." *Cranor*, 22 B.L.R. at 1-5 (discussing *Melnick*).

[20]Dr. Hippensteel both found that there were no large opacities consistent with pneumoconiosis, and noted the presence of a 2cm diameter opacity in Mr. R.'s lungs that, in his view, was not consistent with complicated pneumoconiosis. Therefore, Dr. Hippensteel's comments do not refute the presence of a large pulmonary opacity; rather his comments go to the cause of the opacity.

[21]I also note that none of Mr. R.'s CT scans revealed the presence of a large pulmonary opacity.

Second, a physician might find a profusion greater than 1/0 but make a note that the disease is "not CWP etiology unknown," as was the case in *Cranor*. *Id*. at 1-4. In that situation, the physician's comments are directed not to the presence of pneumoconiosis, but the etiology of the diagnosed pneumoconiosis. *Id*. at 1-5, 1-6. Accordingly, an administrative law judge should consider those comments under 20 C.F.R. § 718.203 regarding the etiology of the claimant's pneumoconiosis.

Turning to the present claim, and with those instructions in mind, I note that Dr. Hippensteel's observation regarding the March 17, 2006 chest x-ray is a *Cranor* comment, because he opines the opacities are not suggestive of coal workers' pneumoconiosis. Therefore, I will consider Dr. Hippensteel's interpretation of the March 17, 2006 x-ray positive for pneumoconiosis and discuss etiology if necessary in a subsequent discussion on etiology of the pneumoconiosis.

As previously summarized above, Mr. R.'s admissible radiographic record consists of six chest x-rays. Dr. Forehand, a B reader, found that the June 26, 2003 chest x-ray was positive for pneumoconiosis. However, Dr. Wheeler, a dual-qualified radiologist, read the film as negative for pneumoconiosis. Due to Dr. Wheeler's superior qualifications, I find that his assessment is the most probative.[22] Accordingly, I find the June 26, 2003 chest x-ray is negative for pneumoconiosis.

In light of the undisputed interpretation by Dr. Forehand, the September 9, 2003 chest x-ray is positive for pneumoconiosis. Dr. Hippensteel's uncontested opinion of the March 17, 2004 chest x-ray establishes it as positive for pneumoconiosis. Similarly, the uncontested opinion of Dr. Robinette establishes the presence of pneumoconiosis in the June 7, 2004 x-ray. Additionally, the uncontested consensus of Dr. Alexander, Dr. Pathak, and Dr. Hippensteel establishes that the May 19, 2005 x-ray is positive for pneumoconiosis.[23] Finally, in light of the uncontested opinion of Dr. Fino, I find that the December 1, 2005 x-ray is negative for pneumoconiosis.

In summary, four chest x-rays are positive for simple pneumoconiosis, and two are negative. As a result, the four positive interpretations represent the preponderance of the radiographic record, and Mr. R. is able to establish the presence of pneumoconiosis in his lungs under 20 C.F.R. § 718.202(a)(1).

<u>*Compton* Analysis</u>

Although the preponderance of the radiographic evidence is positive for simple pneumoconiosis, I must consider, under *Compton*, all the other relevant medical evidence on whether Mr. R. has pneumoconiosis. In the absence of a probative biopsy test result, the

[22]*See Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003); *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.) (greater probative weight may be given to the interpretations of a dual qualified radiologist in comparison to a physician who is only a B reader).

[23]Although Dr. Fino also interpreted this chest x-ray, he commented only on the presence of complicated pneumoconiosis and did not opine on the presence of simple pneumoconiosis.

remaining relevant medical evidence is the diverse medical opinions concerning Mr. R.'s pulmonary condition. Prior to considering the various medical assessments of Mr. R.'s pulmonary condition, a review of the other medical evidence in the record helps to understand the medical opinions.

CT Scans

Dr. Paul S. Wheeler, board certified radiologist, reviewed Mr. R.'s CT scan dated July 11, 2002 (EX 1). Dr. Wheeler found it negative for pneumoconiosis. There was minimal interstitial infiltrate compatible with pulmonary vascular congestion more likely than interstitial lung disease in posterior lower lobes and posterior CPAs. Emphysema with areas of decreased and distorted upper lung markings and minimal dilated hilar pulmonary arteries. Moderate arteriosclerosis aortic arch and ascending thoracic aorta. Focal arteriosclerosis rest of aorta. Few small subcapsular cysts and few tiny calcified granulomata in right lower lobe liver.

Dr. John Randolph Forehand, board certified in allergy and immunology, reported that Mr. R. had a CT scan with contrast of the chest on July 22, 2003, which revealed infiltrates in the left lung (CX 6). Dr. William W. Scott, board certified radiologist, also reviewed the July 22, 2003 CT scan (EX 3). Dr. Scott saw infiltrate in the left lower lobe and posterior left upper lobe compatible with pneumonia. Increased markings, posterior lungs: dependent lung water, minimal edema or fibrosis, possibly due to positioning. Emphysema with bullous changes in apices. Arteriosclerosis aorta and coronary artery calcifications present. No evidence of silicosis or CWP.

Dr. Doo Yung Kwun, board certified in pediatrics, reported on September 27, 2005 that Mr. R. had a chest CAT scan on an unknown date that did not show lung cancer (CX 7).

Medical Opinion Evidence

Treatment Records[24]
(CX 4, CX 7)

On July 10, 2002, Mr. R. was treated by Dr. Matthew Wood for a non-pulmonary condition, but his physical exam contained a note that his lungs were clear to auscultation and palpation with even and equal inspiration. After a consultation, Dr. Chris Kennedy found that Mr. R. had right ventricle hypertrophy and ventricular dilation secondary to chronic obstructive pulmonary disease, but noted that Mr. R. was not at cardiac risk.

Dr. Kwun reported on September 27, 2005 that Mr. R. had a negative TB skin test.

[24]I summarize only those notes related to Mr. R.'s pulmonary health.

Dr. J. Randolph Forehand
(DX 8, CX 5)

On June 26, 2003, Dr. Forehand evaluated Mr. R.'s pulmonary health. Mr. R. was miner with 32 years underground. His last coal mine employment was as a contractor, loader operator from March 1994 until March 1995. Mr. R. smoked cigarettes from 1945 until 1999 at the rate of half of one pack per day. Mr. R. experienced shortness of breath for five years, and chest pain with exertion.

Upon physical exam, Mr. R. had diminished breath sounds and crackles at the bases. The chest x-ray was positive for coal workers' pneumoconiosis, the pulmonary function test showed a normal ventilatory pattern, Mr. R. had arterial hypoxemia, and the EKG showed no acute changes. Dr. Forehand diagnosed coal workers' pneumoconiosis based on "HX, PE, CXR, ABG," with an etiology of coal mine dust exposure. Dr. Forehand found that Mr. R. had a significant respiratory impairment, with insufficient residual oxygen transport capacity to continue in his last coal mine job. Mr. R. was unable to work and totally and permanently disabled. Coal workers' pneumoconiosis was the sole factor contributing to Mr. R.'s respiratory impairment.

On July 22, 2003, Mr. R. was treated by Dr. Forehand for chronic respiratory symptoms including shortness of breath. Mr. R. smoked for 40 years, quitting about 10 years ago. Upon physical exam, Mr. R. appeared cyanotic. A chest x-ray dated June 23, 2003 revealed coal workers' pneumoconiosis and a possible right hilar mass. A CT scan on July 22, 2003 revealed infiltrates in the left lung. Dr. Forehand's impression was that Mr. R. had coal workers' pneumoconiosis and pneumonia, and he placed Mr. R. on antibiotics and home oxygen. At a follow-up appointment on July 25, 2003, Dr. Forehand found that Mr. R.'s pneumonia was resolving. On September 9, 2003, Mr. R. returned to Dr. Forehand for a follow-up. A chest x-ray showed that Mr. R.'s pneumonia was resolving and there was evidence of coal workers' pneumoconiosis. Dr. Forehand recommended that Mr. R. remain on home oxygen so he could continue to work on his farm.

On April 20, 2004, Dr. Forehand treated Mr. R. for sinusitis, and noted that Mr. R. was still experiencing exertional shortness of breath. Upon physical exam, Mr. R. had inspiratory crackles at the bases, bilaterally. Dr. Forehand also noted that Mr. R. had coal workers' pneumoconiosis.

On June 23, 2005, Dr. Forehand did an arterial blood gas study, found resting hypoxemia stemming from coal workers' pneumoconiosis, and planned to recertify Mr. R.'s use of home oxygen.

Dr. Emory H. Robinette
(CX 5)

On June 7, 2004, Dr. Robinette, board certified in internal medicine and pulmonary disease, evaluated Mr. R.'s pulmonary health. Mr. R. complained of increased shortness of breath with exertion, and a history of burning chest discomfort. Mr. R. had been on

supplemental oxygen since the spring of 2003. He had pneumonia in the past, as well as recurrent bronchitis with cough, congestion, and dyspnea. Mr. R. stopped smoking 8 years ago, and before that he smoked 1 pack of cigarettes per day and has at least a 45 pack-year[25] smoking history. Mr. R. worked in the mines for 33 years, underground for more than 20 years, before stopping in 1996.

Upon physical exam, breath sounds were diminished on auscultation and Mr. R. had poor air movement. There was marked prolongation of the expiratory phase. There were no wheezes or crackles. The chest x-ray was positive for pneumoconiosis and emphysema. The pulmonary function test showed normal spirometry and significant reduction of diffusion capacity. The arterial blood gas study revealed resting hypoxemia. The cardiopulmonary stress test revealed evidence of a moderate area of ischemia involving the left ventricle, marked right ventricular enlargement, and normal left ventricular systolic function with a normal ejection fraction. A cardiac catheterization revealed a chronic occluded distal circumflex system and coronary artery disease. Mr. R. had mild hypertension.

Dr. Robinette's impression was that of coal workers' pneumoconiosis, dyspnea upon exertion with severe impairment of diffusion capacity and probably emphysematous change, ASCVD with a history of prior myocardial infarction and inferolateral ischemia, and hyperlipidemia. Dr. Robinette concluded that Mr. R. had occupational pneumoconiosis which occurred as a direct consequence of his mining employment. Mr. R.'s reduction in diffusion capacity is obviously unrelated to his cardiac disease and is directly related to his coal dust inhalation and a history of cigarette smoking in the distant past.

Dr. Kirk E. Hippensteel
(DX 9A, DX 8)

Dr. Hippensteel, board certified in internal medicine, pulmonary disease, and critical care medicine, evaluated Mr. R.'s pulmonary health on March 17, 2004. Mr. R. worked underground in the coal mines for 33 years. He retired in 1996 and started working on a farm. His last job was as owner and superintendent of a mine, which required crawling but not heavy lifting. Mr. R. said that he has had breathing trouble since at least 1996. His medical history does not include asthma or tuberculosis. Mr. R. gets chest pain from walking too far, and he uses oxygen when he dances. He does not take any breathing medications.

Upon physical exam, Mr. R. had scattered rales in both bases with no wheezes. The chest x-ray showed increased interstitial markings or irregular type. There was no evidence of large opacities, and the changes were not typical for coal workers' pneumoconiosis. There was evidence of bullous disease in the right upper lobe, and also arteriosclerosis of aorta. The spirometry and lung volumes were normal. The diffusion capacity was markedly reduced. He has hypoxemia at rest and his carboxyhemoglobin was in the upper limits of normal. The electrocardiogram showed probable old infarction and a suggestion of right ventricular hypertrophy.

[25]A pack-year equals the consumption of one pack of cigarettes a day for one year.

Dr. Hippensteel also reviewed Dr. Forehand's 2003 evaluation. Dr. Hippensteel concluded that Mr. R.'s interstitial markings were not referable to heart failure, acute inflammation, or coal workers' pneumoconiosis. Coal workers' pneumoconiosis was ruled out because the markings were irregular in shape and basilar in predominance. The cause of the lung scarring is unknown, but is associated with cardiac dysfunction and a smoking history, which is known to aggravate cardiac dysfunction. Cardiac dysfunction is also a known cause of gas exchange abnormalities, and although Mr. R.'s abnormalities are sufficient to keep him from returning to the mines, Dr. Forehand fails to comment about his abnormal electrocardiogram findings or cardiac potential for affecting gas exchange function. In Dr. Hippensteel's opinion, Mr. R.'s cardiac function, even without congestive heart failure, is a significant contributing factor to his gas exchange impairment added to his basilar lung disease.

At a deposition on August 28, 2006, Dr. Hippensteel noted that he reviewed Dr. Robinette's July 7, 2004 letter and report. Dr. Hippensteel noted that he reviewed the July 2002 treatment records, the CT scan interpretations by Dr. Scott and Dr. Wheeler, Dr. Forehand's progress records, Dr. Fino's report, the chest x-ray interpretations of Dr. Pathak and Dr. Alexander, and Dr. Kwun's record. Dr. Hippensteel listed coal mining and smoking as Mr. R.'s risk factors for lung disease. He also had frequent headaches. Mr. R.'s smoking and coal mining were significant. At Dr. Hippensteel's physical exam, Mr. R. had an S4 gallop, which is found in people with hypertension or some changes in left ventricular function. The location of rales make a difference about whether it relates to the heart or pneumoconiosis, which would be expected in the upper lobes. Mr. R.'s chest x-ray was consistent with pneumoconiosis but not coal workers' pneumoconiosis. Mr. R.'s electrocardiogram also showed abnormalities. Mr. R.'s gas exchange abnormalities qualified for disability under the regulations. Mr. R. also had impaired diffusion. However, these abnormalities are not specific to lung disease alone but can be aggravated by heart disease. Mr. R. did have some evidence of heart disease contributing to his gas exchange impairment, and combining that impairment with his diffusion impairment was the cause of his total impairment. Mr. R. did not have any mechanical ventilatory impairment, with normal spirometry and lung volumes. Although Dr. Forehand's pulmonary function tests were not an accurate reflection of Mr. R.'s ventilatory function due to lack of cooperation, they still did not show evidence of abnormalities. Mr. R.'s blood gas studies and his diffusion capacities were not normal in any of the testing reviewed by Dr. Hippensteel.

Regarding Mr. R.'s March 17, 2004 chest x-ray, the opacities were predominant at the lung bases, and opacities from coal mine dust exposure are usually first in the upper lobes then diffuse throughout the lungs. The opacities were irregular in shape, and although this can occur in coal workers' pneumoconiosis, it is more common in other types of pneumoconiosis and idiopathic pulmonary fibrosis. The CT scans interpreted by Dr. Wheeler and Dr. Scott corroborate that the abnormalities visible on the CT scans were not coal workers' pneumoconiosis. They also corroborated Dr. Hippensteel's chest x-ray interpretation, and showed that there was some acute change, maybe pneumonia, at the time of the 2003 CT scan. CT scanning is a medically-recognized, reliable method for diagnosing pulmonary conditions, and it is more sensitive and specific to interstitial lung diseases than the chest x-ray. The March 17, 2004 chest x-ray contained no evidence of complicated pneumoconiosis or a large opacity. The two CT scans also did not show large opacities. The absence of radiographic findings does not rule out a lung impairment due to coal mine dust exposure. However, Mr. R.'s oxygen

transfer and diffusion impairments are not related to coal mine dust because his x-ray and CT scan show other diseases not referable to coal workers' pneumoconiosis that are the cause of the abnormalities. He has interstitial changes in his lung bases of an irregular type that are compatible, and have continued to be present as noted by Dr. Fino, with idiopathic pulmonary fibrosis. This is unrelated to coal mining; it is a disease of the general public. He also has bullous changes in his upper lobes not associated with coal macules or large opacities, and it is a cause of diffusion impairment. Mr. R.'s arteriosclerotic disease correlates with his electrocardiogram abnormalities, which are a factor in his gas exchange impairment. Those findings show diseases separate from his coal mine exposure that have caused these abnormalities and provide explanations for Mr. R.'s examinations. Mr. R. does not have x-ray evidence of coal mine related disease, and he has evidence of diseases separate from his coal mining that are known to cause diffusion abnormalities, and that combination makes it possible to state with reasonable certainty that this diffusion impairment is related to those diseases separate from his coal mine dust exposure. The reduction in diffusion capacity is unrelated to Mr. R.'s cardiac disease because Mr. R. was not in heart failure at the time of the test based on the natriuretic peptide test. Mr. R.'s lung diseases are unrelated to coal mine dust exposure and are not legal or medical pneumoconiosis.

Regarding the May 19, 2005 x-ray, Dr. Hippensteel reviewed the film and its interpretations by other physicians. That x-ray had evidence of a large opacity in the left upper lung zone. Dr. Hippensteel also compared this x-ray to two others, dated June 7, 2004 and December 1, 2005. This comparison provides a "distinct medical advantage" with chronic diseases like coal workers' pneumoconiosis. In this case, the comparison shows that Mr. R. does not have complicated pneumoconiosis. There was no large opacity on the June 7, 2004 or the December 1, 2005 x-rays. This suggests that there was a consolidated area of pneumonia that had cleared up by the time of the December 1, 2005 x-ray. There is no possibility that the May 2005 lesion was due to coal mine dust exposure, because it developed too quickly and would not have mostly cleared out just six months later. The comparison of the series makes the case that an abnormality that would be considered possibly from pneumoconiosis is not related at all.

Dr. Gregory J. Fino
(EX 5, EX 9)

Dr. Fino, board certified in internal medicine and pulmonary disease, evaluated Mr. R.'s pulmonary health on December 1, 2005. Mr. R. smoked for 46 years, from 1948 until 1994. He was on supplemental oxygen, and also used his inhaler on the day of Dr. Fino's examination. Mr. R. worked underground in the coal mining industry for 30 years, stopping in 1995. His last job was as a mine operator, and he did no heavy labor and stayed outside the mine the entire time. Mr. R.'s shortness of breath has been present for 18 years and is worsening but it does not interfere with his usual daily activities. He becomes dyspneic when walking on level ground, ascending one flight of steps, walking up grades, lifting and carrying, and performing manual labor. Mr. R. is limited in what he can do because of his breathing. Mr. R. also complained of chest pain. Mr. R.'s medical history included black lung diagnosed in 1994, a weak heart diagnosed in 1994, and pneumonia. He did not have a history of tuberculosis, emphysema, asthmas, bronchitis, bronchiectasis, or frequent colds.

Upon physical exam, Mr. R. had no cyanosis, clubbing, or edema. Dr. Fino heard rales at the lung bases. The chest x-ray was not normal, displaying irregular interstitial markings throughout the right lung, with more in the lower and middle zones than in the upper zones. The left lung had no abnormalities in the upper lobe, but there was linear scarring in the middle zone, and increased interstitial markings on the middle and lower zones. There were no rounded opacities consistent with simple coal mine dust related pneumoconiosis. The linear scarring in the left lung is not consistent with complicated coal workers' pneumoconiosis. These changes are consistent with an idiopathic interstitial pulmonary fibrosis. The spirometry was normal. There was no obstruction, restriction, or ventilatory impairment. Lung volumes were not performed due to a technical malfunction. The diffusion capacity was reduced. The carboxyhemoglobin was normal. On room air, the resting arterial blood gas study showed moderate to moderately severe hypoxemia.

Dr. Fino also reviewed the medical record in this claim. Dr. Fino diagnosed Mr. R. with disabling, diffuse, interstitial pulmonary fibrosis. Mr. R.'s chest x-ray does not show coal workers' pneumoconiosis because that disease is characterized by rounded opacities beginning in the upper lung zones. Mr. R.'s x-ray contained irregular opacities and did not have any opacities in the upper left lung. The presence of irregular opacities is inconsistent with a diagnosis of coal workers' pneumoconiosis. Opacities found in the lower lung zones only do not indicate a coal dust related lung condition. Mr. R. has an irregular fibrosis that is idiopathic and unrelated to coal dust inhalation. After citing several studies, Dr. Fino wrote that because Mr. R. did not have biopsy or chest x-ray evidence of coal workers' pneumoconiosis, there was not sufficient evidence to correlate his lung disease with coal dust inhalation. He also added that "[i]f there is clear-cut evidence of classical pneumoconiosis either radiographically or pathologically associated with the diffuse interstitial fibrosis, then it is reasonable to assume that the two are connected."

Dr. Fino concluded that 1) there was insufficient medical evidence to justify a diagnosis of coal workers' pneumoconiosis, either clinical or legal; 2) Mr. R. had a disabling respiratory impairment; and 3) from a respiratory standpoint Mr. R. was disabled from returning to his last mining job or job requiring similar effort.

At a deposition on August 30, 2006, Dr. Fino noted that Mr. R. might have been outside the mines one year out of 30, but that his coal dust exposure was "clearly" enough to cause coal workers' pneumoconiosis if he was susceptible. He noted that rales indicate the presence of diffuse fibrosis in the lungs, and that Dr. Forehand and Dr. Hippensteel also heard rales in Mr. R.'s chest; a fairly persistent finding since 2003. Dr. Fino was surprised that Dr. Hippensteel's lung volume test in March 2004 was normal because Mr. R. has a lot of pulmonary fibrosis. The other physicians' spirometric testing data was normal. Mr. R.'s diffusion capacity shows that he does have problems, as shown in the data from Dr. Fino, Dr. Hippensteel, and Dr. Forehand. Dr. Fino's opinion was that Mr. R. had an oxygen transfer impairment that leaves him "completely disabled for any type of labor" including above-ground or underground mining. Dr. Fino noted that in his chest x-ray he did not see bullous emphysema.

Dr. Fino commented that CT scans have been used for diagnosis and treatment for about 20 years, and that they are "far better" than a regular chest x-ray for identifying early changes of

any type of lung disease. In Dr. Fino's opinion, in coal workers' pneumoconiosis cases, a CT scan is a better way to pick up early simple and complicated pneumoconiosis compared to using a chest x-ray. Dr. Fino also noted that the absence of radiographic abnormalities related to coal mine dust related disease does not rule out coal mine related lung disease using either chest x-rays or CT scans. Dr. Fino said that CT scanning is generally recognized in the medical profession as an appropriate diagnostic tool in general, and in occupational lung diseases in particular. Dr. Scott may have seen emphysema on the CT scan that Dr. Fino could not see on the chest x-ray because the CT scan is more sensitive.

Dr. Fino noted that diffuse interstitial pulmonary fibrosis starts and the bottom and works upwards, whereas coal dust changes are focal fibrosis. Neither Mr. R.'s smoking habit nor his coal mine dust exposure caused him any respiratory impairment. Based on the chest x-rays, Mr. R. had diffuse interstitial fibrosis, not coal workers' pneumoconiosis. It is unusual to have diffusing capacity abnormality, without spirometry abnormality, due to coal mine dust inhalation alone. Dr. Fino said he turned to the medical literature to determine whether there was a relationship between interstitial fibrosis and coal mine dust. He said that although there might be individuals with both interstitial fibrosis and coal workers' pneumoconiosis, no cause and effect relationship had been established. In the absence of biopsy evidence of chest x-rays showing rounded opacities, this is just a typical case of interstitial pulmonary fibrosis. A severe impairment, such as Mr. R.'s, would not go along with coal dust associated interstitial pulmonary fibrosis. Dr. Fino also noted that there was no evidence of a large opacity on the December 1, 2005 chest x-ray. The May 19, 2005 chest x-ray contains a 2cm by 1cm oval-shaped mass or solid opacity. This could be a neoplasm, scar, or complicated pneumoconiosis. Dr. Fino's opinion was that it did not look like complicated pneumoconiosis, but he would consider scarring or a tumor. Dr. Fino agreed with Dr. Alexander that it could have been complicated coal workers' pneumoconiosis, focal scarring, or lung cancer. Before May 2005, nobody suggested the possibility of a large opacity. None of the other radiographic evidence contained a large opacity. The 1x2 cm opacity visible in May 2005 was gone by the time Dr. Fino did an x-ray in December 2005, but there was a 2cm long, pencil-lead-thick scar in that same location in December 2005. This lesion could not have been related to coal mine dust related lung disease. A complicated lesion related to coal mine dust exposure would not appear within less than one year, such as between June 2004 and May 2005. The fact that it came on so quickly and went away so quickly suggested to Dr. Fino that it was an infection such as pneumonia. There were no medical records to indicate whether he was having any particular problem at that time.

Discussion

Following their treatments of Mr. R., Dr. Wood, Dr. Kennedy, and Dr. Kwun did not specifically address whether Mr. R. had pneumoconiosis. The other treating physician, Dr. Forehand, diagnosed coal workers' pneumoconiosis. Similarly, based on pulmonary evaluations, Dr. Robinette and Dr. Hippensteel concluded that Mr. R. had pneumoconiosis. In contrast, following a pulmonary evaluations and record review, Dr. Fino concluded Mr. R. did not have coal workers' pneumoconiosis. To resolve this conflict in medical opinion, I must assess the relative probative value of each respective opinion in terms of documentation, reasoning, and treating physician status.

Regarding the first probative value consideration, documentation, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co*., 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter. Finally, in light of the extensive relationship a treating physician may have with a patient, the opinion of such a doctor may be given greater probative weight than the opinion of a non-treating physician. *See Downs v. Director, OWCP*, 152 F.3d 924 (9th Cir. 1998) and 20 C.F.R. §718.140 (d).

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co*., 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91 (1988).

Third, according to 20 C.F.R. § 718.104(d), in evaluating medical opinion, an administrative law judge must consider the relationship between the claimant and any treating physician. Depending on the duration, frequency, and extent of the treatment, the opinion of a physician who provided treatment for pulmonary concerns may be entitled to more probative weight than the assessment of a non-treating physician. At the same time, no presumption of greater probative weight exists merely based on a physician providing treatment. *See Consolidation Coal Co. v. Director, OWCP [Held]*, 314 F.3d 184 (4th Cir. 2002).

With these principles in mind, I first note that consistent with my determination regarding the preponderance of the chest x-rays, Dr. Forehand, Dr. Robinette, and Dr. Hippensteel presented documented and reasoned conclusions that Mr. R. has pneumoconiosis. Dr. Forehand is also Mr. R.'s treating physician.

Dr. Fino concluded Mr. R. did not have coal workers' pneumoconiosis based on the absence of positive biopsy or chest x-ray evidence in the record. However, I have determined that the preponderance of the radiographic evidence is positive for pneumoconiosis. Therefore, Dr. Fino's conclusion loses probative weight because of a documentation shortfall.

In summary, the opinions of Dr. Forehand, Dr. Robinette, and Dr. Hippensteel concerning the presence of simple pneumoconiosis are reasoned and consistent with the radiographic evidence. Due to inaccurate documentation, Dr. Fino's opinion regarding coal workers' pneumoconiosis has diminished probative value. Accordingly, the preponderance of the probative medical opinion supports, rather than refutes, a finding that Mr. R. has simple pneumoconiosis based on the preponderance of the radiographic evidence. Consequently, Mr. R. has proven the first requisite element of entitlement under 20 C.F.R. § 718.202(a)(1).

Issue # 3 – Pneumoconiosis Arising Out of Coal Mine Employment

Once a claimant has proven the existence of pneumoconiosis, 20 C.F.R. § 718.203(a) requires that he also establish that his pneumoconiosis arose at least in part from his coal mine employment. According to 20 C.F.R. § 718.203(b), if the claimant was employed in coal mining for ten or more years, a rebuttable presumption that the pneumoconiosis is due to coal mine employment exists.

Since I determined that Mr. R. had over 21 years of coal mine employment, he is entitled to the regulatory rebuttable presumption that his pneumoconiosis was related to his work as a coal miner. As previously discussed, in his interpretation of the March 17, 2006 chest x-ray, Dr. Hippensteel opined that the shape of the opacities were not suggestive of coal workers' pneumoconiosis. I consider Dr. Hippensteel's comment as evidence that Mr. R.'s pneumoconiosis is not related to his coal mine employment. However, Dr. Hippensteel noted that although irregularly shaped opacities are not common in coal workers' pneumoconiosis, they can occur. Accordingly, I find that Dr. Hippensteel's comment is equivocal, and insufficient evidence exists to rebut the presumption that Mr. R.'s pneumoconiosis is due to his coal mine employment. As a result, through the use of a presumption, Mr. R. has proven that he has coal worker's pneumoconiosis.

Issue # 4 – Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204(b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204(b)(1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

As previously discussed, the radiographic is insufficient to prove the presence of complicated pneumoconiosis. As a result, Mr. R. must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood gas studies, medical opinion, or the presence of cor pulmonale with right-sided heart failure.

Pulmonary Function Tests[26]

Exhibit	**Date / Doctor**	**Age / Height**	**FEV_1 pre[27] post[28]**	**FVC pre post**	**MVV pre post**	**FEV_1 / FVC pre post**	**Qualified[29] pre post**	**Comments**
DX 8	June 26, 2003 Dr. Forehand	75 68"	3.01	4.83	61	62.3%	No[30]	Invalid per Dr. Michus 7/30/03 (DX 8)
CX 6	Sept. 3, 2003 Dr. Forehand							No airflow limitation.
CX 6	April 20, 2004 Dr. Forehand							Airflow limitation.
DX 9A	Mar. 17, 2004 Dr. Hippensteel	76 68"	2.84 2.49	3.81 3.74	78 --	74.5% 66.6%	No No	Spirometry normal, MVV mildly decreased. Diffusion markedly decreased.
CX 5	June 7, 2004 Dr. Robinette							Normal spirometry, normal lung volumes. Significant reduction in diffusion capacity.
EX 5	Dec. 1, 2005 Dr. Fino	78 68"	2.37	3.82	--	62.0%	No	

None of the pulmonary function tests reveal qualifying results. Therefore, the preponderance of the pulmonary function tests fail to establish total disability under 20 C.F.R. §718.204(b)(2)(i).

[26]I have not the July 22, 2003 hospitalization pulmonary tests because Dr. Forehand only noted the FEV1 was 93% of predicted and did not provide the predicted value.

[27]Test result before administration of a bronchodilator.

[28]Test result after administration of a bronchodilator.

[29]Under 20 C.F.R. § 718.204(b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718 (2001), and either the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal or less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[30]Qualifying FEV1 value is 1.73 or less.

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO_2 (rest) pCO_2 (exercise)	pO_2 (rest) pO_2 (exercise)	Qualified	Comments
DX 8	June 26, 2003 Dr. Forehand	30 32	62 43	Yes[31] Yes[32]	Evidence of arterial hypoxemia.
CX 6	July 22, 2003 Dr. Forehand	26	47	Yes[33]	On room air, during hospitalization
DX 9A	Mar. 17, 2004 Dr. Hippensteel	36.5	54.9	Yes[34]	Hypoxemia at rest. Carboxyhemoglobin at upper normal range.
CX 5	June 7, 2004 Dr. Robinette				Resting hypoxemia.
CX 3, 6	June 23, 2005 Dr. Forehand	33	53	Yes[35]	Room air.
EX 5	Dec. 1, 2005 Dr. Fino	36.7	53.4	Yes	

Under the provisions of 20 C.F.R. § 718.204(b)(2)(ii), in the absence of contrary probative evidence, a qualifying arterial blood gas study under Appendix C of Part 718 shall establish a miner's total disability. Adjudication under this regulatory section requires a five step process. First, an administrative law judge must determine whether the tests conform to the arterial blood gas study procedural requirements in 20 C.F.R. § 718.105. Second, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. Third, the results are compared to the qualifying values for the various tests listed in Appendix C to determine whether the test reaches the total disability thresholds. Fourth, a determination must be made whether the preponderance of the conforming, valid, and qualifying arterial blood gas studies supports a finding of total disability under the regulation. Fifth, if the preponderance of conforming tests establishes total disability, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, then it must be given appropriate evidentiary weight and a determination is then made to see if it outweighs the blood gas study evidence that supports a finding of total respiratory disability. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987).

Mr. R.'s arterial blood gas studies appear to conform to the regulatory standards and no physician has questioned their validity. Additionally, since every test reached the qualifying levels for a determination of total disability, the preponderance of the arterial blood gas studies establishes total disability. Finally, none of the physicians to consider Mr. R.'s respiratory

[31]For a pCO^2 of 30, the qualifying pO^2 is 70 or less.

[32]For a pCO^2 of 32, the qualifying pO^2 is 68 or less.

[33]For a pCO^2 of 26, the qualifying pO^2 is 74 or less.

[34]For a pCO^2 of 37, the qualifying pO^2 is 63 or less.

[35]For a pCO^2 of 33, the qualifying pO^2 is 67 or less.

capacity to oxygenate his blood concluded he was not totally disabled. Accordingly, Mr. R. has established a totally disabling respiratory impairment under 20 C.F.R. § 718.204(b)(2)(ii).

Issue # 5 – Total Disability Due to Coal Workers' Pneumoconiosis

Because Mr. R. has established three of the four requisite elements for his entitlement to benefits, the award of benefits rests on the determination of whether his respiratory disability is due to coal workers' pneumoconiosis. Proof that a claimant has a totally disabling pulmonary disease does not by itself establish the impairment is due to pneumoconiosis. Under 20 C.F.R. § 718.204(c)(1), absent regulatory presumptions in favor of a claimant, the claimant must demonstrate that pneumoconiosis was a substantially contributing cause of his total disability by showing the disease: 1) had a material, adverse effect on his respiratory or pulmonary condition; or, 2) materially worsened a totally disabling respiratory impairment caused by a disease or exposure unrelated to pneumoconiosis. Additionally, 20 C.F.R. § 718.204(c)(2) mandates that "the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report."

Only one of Mr. R.'s treatment physicians, Dr. Forehand, provided an opinion on the cause of Mr. R.'s total disability. Dr. Forehand isolated Mr. R.'s coal dust exposure as the cause of his respiratory impairment. Dr. Robinette pointed to Mr. R.'s coal dust inhalation and his smoking history as the cause of his reduction in diffusion capacity. Dr. Hippensteel attributed Mr. R.'s total disability to idiopathic pulmonary fibrosis and bullous changes. Dr. Fino did not provide an opinion on the cause of Mr. R.'s total disability, but specifically ruled out both his smoking and coal mine dust exposure as causes. Due to this medical dispute, I return to assessing the probative value of the opinions.

Dr. Forehand provided a documented opinion that was based on his treatment of Mr. R. and formal black lung evaluation. As a treating physician, Dr. Forehand was well-positioned to provide a probative medical assessment of Mr. R. However, Dr. Forehand's conclusion that Mr. R.'s respiratory impairment was caused by his coal dust exposure ignores his other risk factor of an extensive smoking history. Therefore, Dr. Forehand's opinion on the cause of Mr. R.'s total disability loses probative weight because it is not adequately reasoned in light of Mr. R.'s smoking history.

Dr. Hippensteel's opinion was not documented because it relied, in part, on his conclusion that the radiographic record did not reveal coal workers' pneumoconiosis. However, as noted above, through the radiographic record and the use of a regulatory presumption, Mr. R. was able to show that he has clinical coal workers' pneumoconiosis. Dr. Hippensteel relied on the absence of radiographic findings indicating coal workers' pneumoconiosis as the basis for his finding that Mr. R.'s other lung diseases, and not any disease caused by coal mine dust exposure, caused his respiratory impairment. Given my prior determination that Mr. R. has clinical coal workers' pneumoconiosis, Dr. Hippensteel's rationale for excluding coal dust related disease as a possible etiology of Mr. R.'s total pulmonary disability loses probative weight.

Dr. Fino provided a reasoned analysis for his elimination of coal workers' pneumoconiosis as the cause of Mr. R.'s impairment. However, his assessment rests on

inaccurate documentation because he did not believe Mr. R. had clinical coal workers' pneumoconiosis which contrary to my determination. Consequently, Dr. Fino's disability causation opinion has diminished probative value.

Dr. Robinette provided a documented opinion based on a physical examination and testing of Mr. R.[36] Additionally, in a reasoned opinion, after diagnosing clinical coal workers' pneumoconiosis consistent with my findings, Dr. Robinette explained that the Mr. R.'s markedly reduced diffusion capacity enabled him to identify Mr. R.'s exposure to coal mine dust, rather than his cardiac problems, as a cause of his significant respiratory impairment, in addition to a history of cigarette smoking.

In summary, due to various documentation and reasoning shortfalls, the assessments of Dr. Forehand, Dr. Hippensteel, and Dr. Fino on the cause of Mr. R.'s respiratory disability have diminished probative weight. The remaining medical assessment by Dr. Robinette is sufficiently documented and reasoned, represents the preponderance of the probative medical opinion, and establishes that Mr. R. is totally disabled due to coal workers' pneumoconiosis. Accordingly, he is able to prove the final element of entitlement.

Date of Entitlement

Under 20 C.F.R. § 725.503(b) in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable from the month of onset of total disability. When the evidence does not establish when the onset of total disability occurred, then benefits are payable starting the month the claim was filed. The BRB has placed the burden on the miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the claimant receives benefits only from the date the claim was filed. The BRB also stated in *Johnson*, "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented."

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he was not totally disabled. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989). This principle may come into play if evidence indicates there was a period of time after the filing of the claim during which the miner was not totally disabled. One example is the situation in *Rochester and Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600 (3d Cir. 1989), where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not

[36]Although the numerical results of Dr. Robinette's testing were not included in the record, they are consistent with the rest of the testing data in the record; hypoxemia in the blood gas study and reduced diffusion capacity in the pulmonary function test.

yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to the date the miner filed his claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

However, if no intervening medical evidence raises the possibility of total disability not being present between the claim filing date and the first medical evaluation establishing total disability, then a different set of principles is applicable. In this situation, when the first medical examination after the claim is filed leads to a finding of total disability, the date of the examination does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam, the miner became totally disabled. *See Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1985) (the date the claimant is "first able to muster evidence of total disability is not necessarily the date of onset").

Mr. R. filed this claim in May 2003. The first definitive evidence of total disability is in the June 2003 arterial blood gas study done by Dr. Forehand. Therefore, no contrary evidence exists to set the entitlement date earlier than when Mr. R. filed his claim in May 2003. As a result, Mr. R.'s black lung disability benefits are payable beginning May 1, 2003.

Augmentation

Benefits under the Act may be augmented for a person who meets the criteria of spouse under 20 C.F.R. § 725.204 and the dependency requirements of 20 C.F.R. § 725.205. In light of the parties' stipulation, Mr. R.'s testimony, and the marriage certificate (DX 6), and in the absence of evidence to the contrary, I find that Mrs. T.R. is a qualified spouse, meeting the regulatory requirements for spousal augmentation of Mr. R.'s black lung disability benefits.

CONCLUSIONS

Eastern Coal Co. is the responsible operator in this claim. Through the preponderance of chest x-ray interpretations, and based on the regulatory presumption due to his 21 years of coal mine employment, Mr. R. has established the presence of coal workers' pneumoconiosis in his lungs. Through the preponderance of arterial blood gas studies, he has also proved that he is totally disabled in terms of insufficient respiratory capacity to return to coal mining. Additionally, the more probative medical opinion on the issue of etiology of pneumoconiosis by Dr. Robinette demonstrates that Mr. R.'s totally disabling respiratory impairment is due to coal workers' pneumoconiosis. Consequently, since Mr. R. proved all four requisite elements of entitlement, his claim for benefits under the Act must be granted. The date of entitlement is May 1, 2003, with benefits augmented for his spouse, Mrs. T.R..

ORDER

The claim of **MR. K.P.R.** for benefits under the Act is **GRANTED**. **EASTERN COAL CO.** is ordered to:

1. Pay Mr. K.P.R. all benefits to which he is entitled under the Act and Regulations. Benefits shall commence May 1, 2003, augmented for his spouse Mrs. T.R.

2. Reimburse the Black Lung Disability Trust Fund, pursuant to 20 C.F.R. § 725.602(a), for all interim payments made by the Black Lung Disability Trust Fund to Mr. K.P.R.;

3. Deduct from the payments ordered in paragraph one, as appropriate, the amounts reimbursed to the Black Lung Disability Trust Fund as directed in paragraph two; and

4. Pay to the Secretary of Labor interest as required pursuant to 20 C.F.R. § 725.608(b).

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: August 10, 2007
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Attachment 1

COAL MINE (BLBA) PROCEDURE MANUAL

AVERAGE EARNINGS OF EMPL0YEES IN COAL MINING

Year	***Yearly (125 days)***	***Daily***
1999	$19,340.00	$154.72
1998	19,160.00	153.28
1997	19,010.00	152.08
1996	18,740.00	149.92
1995	18,440.00	147.52
1994	17,760.00	142.08
1993	17,260.00	138.08
1992	17,200.00	137.60
1991	17,080.00	136.64
1990	16,710.00	133.68
1989	16,250.00	130.00
1988	15,940.00	127.52
1987	15,750.00	126.00
1986	15,390.00	123.12
1985	15,250.00	122.00
1984	14,800.00	118.40
1983	13,720.00	109.76
1982	12,698.75	101.59
1981	12,100.00	96.80
1980	10,927.50	87.42
1979	10,878.75	87.03
1978	10,038.75	80.31
1977	8,987.50	71.90
1976	8,008.75	64.07
1975	7,405.00	59.24
1974	6,080.00	48.64
1973	5,898.75	47.19
1972	5,576.25	44.61
1971	5,008.75	40.07
1970	4,777.50	38.22
1969	4,261.25	34.09
1968	3,801.25	30.41
1967	3,662.50	29.30
1966	3,438.75	27.51
1965	3,222.50	25.78
1964	3,031.25	24.25
1963	2,835.00	22.68
1962	2,717.50	21.74
1961	2,645.00	21.16

	Bituminous		**Anthracite**	
Year	**Yearly**	**Daily**	**Yearly**	**Daily**
1960	$2,687.50	$21.50	$2,266.25	$18.13
1959	2,661.25	21.29	2,183.75	17.47
1958	2,415.00	19.32	2,130.00	17.04

1957	2,581.25	20.65	2,172.50	17.38
1956	2,472.50	19.78	2,083.75	16.67
1955	2,275.00	18.20	1,935.00	15.48
1954	2,022.50	16.18	1,775.00	14.20
1953	2,097.50	16.78	1,695.00	13.56
1952	1,880.00	15.04	1,750.00	14.00
1951	1,915.00	15.32	1,692.50	13.54
1950	1,633.75	13.07	1,553.75	12.43
1949	1,465.00	11.72	1,447.50	11.58
1948	1,691.25	13.53	1,342.50	10.74
1947	1,606.25	12.85	1,262.50	10.10
1946	1,362.50	10.90	1,060.00	8.48
1945	1,315.00	10.52	876.25	7.01
1944	1,267.50	10.14	733.75	5.87
1943	1,057.50	8.46	648.75	5.19
1942	857.50	6.86	705.00	5.64
1941	750.00	6.00	657.50	5.26
1940	617.50	4.94	648.75	5.19
1939	598.75	4.79	705.00	5.64
1938	525.00	4.20	657.50	5.26
1937	585.00	4.68	693.75	5.55
1936	552.50	4.42	703.75	5.63
1935	478.75	3.83	707.50	5.66
1934	450.00	3.60	750.00	6.00
1933	375.00	3.00	717.50	5.74
1932	362.50	2.90	726.25	5.81
1931	455.00	3.64	801.25	6.41
1930	560.00	4.48	875.00	7.00
1929	647.50	5.18	863.75	6.91
1928	671.25	5.37	912.50	7.30
1927	723.75	5.79	925.00	7.40
1926	717.50	5.74	1,062.50	8.50
1925	713.75	5.71	1,065.00	8.52
1924	811.25	6.49	1,058.75	8.47
1923	925.00	7.40	1,007.50	8.06
1922	582.50	4.66	907.50	7.26
1921	905.00	7.24	933.75	7.47
1920	817.50	6.54	888.75	7.11